RECOMMENDATIONS TO IMPROVE THE ADMINISTRATION OF THE MHSIP CONSUMER SURVEY

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
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The State Department of Mental Health (DMH) has had a mandate to collect performance outcome data on county mental health programs since the early 1990s. One type of outcome indicator measures client satisfaction with services received from the mental health system. For the Adult System of Care in California, the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey is the instrument used to measure client satisfaction.

The MHSIP Consumer Survey used in California is a 29-item self-report instrument designed to be completed by the client without assistance (see Appendix 1). It consists of four scales that measure general satisfaction, access to services, appropriateness/quality, and outcome. The items are rated on a 5-point Likert scale with "5" being "Strongly Agree" and "1" being "Strongly Disagree." Consumers can also indicate that an item is not applicable to them.

Results from the MHSIP Consumer Survey will provide valuable insights and help initiate any needed changes to the mental health system. Local mental health departments along with consumers can benefit greatly from the information that is gleaned from the MHSIP Consumer Survey. Specifically, mental health departments across the State can use the information and comments from the survey towards system reform and quality improvement efforts. Mental health departments can also use suggestions from consumers to help them better align services to actual consumer needs.

Consumers can also benefit greatly from completing the MHSIP Consumer Survey because they can provide the necessary feedback on the quality of care and service rendered. Through this feedback mechanism, consumers will also play a pivotal role in determining their recovery options. In this way, consumers will not passively receive treatment as mandated by others, but they will be empowered to design their recovery plan and act as reform agents for change.

The DMH developed a training manual, the *Adult Performance Outcome System Clinical Training Manual*, which was disseminated to all county mental health programs to instruct them in the proper administration of the instruments for the Adult Performance Outcome System. The instructions for the MHSIP Consumer Survey emphasize the importance of client confidentiality in administering this instrument, specifically that the client be assured that his or her clinician does not see the client's responses to the MHSIP Consumer Survey:

> Client confidentiality must be assured as part of the process of collecting consumer satisfaction data. To encourage accurate responses, it is crucial that respondents to the MHSIP Consumer Survey be assured confidentiality of their responses so they will not have any fear of retribution. **It should never be returned directly to the clinician** [emphasis in original]. (p. 84)

The training manual also instructs county mental health programs that, if a client should need assistance completing the instrument, a clinician should not be the person providing the assistance:

> …assistance must not be provided directly by the clinician. This is to assure client confidentiality and encourage honesty. Some assistance in the mechanics of how to complete the form may be provided by clerical staff or peer counselor, including reading the form for clients who are unable to read. However, the actual responses to the questions should be made only by the consumer. (p. 106)

During 2002, the California Mental Health Planning Council (CMHPC) received complaints from clients about how the MHSIP Consumer Survey was being administered, which suggested that county mental health programs might not be following these instructions on the correct procedures for assuring client

confidentiality. Consequently, the CMHPC initiated a study on the methods used for administering the MHSIP Consumer Survey and for assisting clients to complete the instrument when they indicated that they needed help.

Methodology

The CMHPC's Quality Improvement Committee conducted this study. It sent out the survey instrument provided in the Appendix. This study had a very high response rate of 80 percent, with 47 out of 59 county mental health departments responding.

The original design of the study was for mental health boards and commissions (MHB/Cs) to collaborate with county mental health departments on conducting the inquiry into administration methods for the MHSIP Consumer Survey. Involvement of MHB/Cs was considered particularly desirable because of consumer representation on MHB/Cs and their insight into issues related to the MHSIP Consumer Survey. However, out of the 47 county mental health departments responding, only 4 MHB/Cs participated in conducting the study in their counties.

This lack of participation may be due to the quick turnaround time for completing the survey instrument. Respondents had only 6 weeks to complete the study, which is really too short a time for MHB/Cs to have meaningful participation. This relatively brief response period was necessitated because the administration method study is the first part of a larger project the Quality Improvement Committee is planning, which had to be completed before the rest of the project could proceed.

Results

The findings from the study point to some degree of clinician contact and involvement in the way MHSIP Consumer Surveys are administered to clients. Almost two-thirds of the counties (64%) reported that clinicians do in fact have contact with clients during the administration of the MHSIP Consumer Survey. However, a more positive finding is that administrative staff provided assistance to clients needing help completing the MHSIP Consumer Survey in 70 percent of the counties responding, and consumer/peer assistants provided help in 49 percent of the counties responding. In addition, based on the MHB/C involvement in a handful of the counties, the CMHPC gained deeper insights into the fears clients have in completing the MHSIP Consumer Survey—fears that had not been anticipated.

Distribution of the MHSIP Consumer Survey

For all the following results concerning the administration methods of the MHSIP Consumer Survey, percentages will not add to 100 percent as many counties had responded that they used a combination of methods.

The primary methods of distribution of the MHSIP Consumer Survey were as follows:

1) Administrative staff (66%)
2) Clinicians (62%)
3) Consumer/peer assistant (28%)
4) Mailing (26%)

The minor methods of administration included an interactive telephone voice recognition system, staff reading the survey to clients over the telephone, and group administration, with each of these methods logging in at 4 percent of the counties responding. Another 2 percent of the counties responding indicated that they used a computer-administered system of administration.

For 32 percent of the counties responding, the clinician was the only route of distribution. Nine counties responding (19%) rely on clinicians to hand out the MHSIP Consumer Survey to clients during home visits. Over and above these nine counties, there are an additional six counties responding (13%) showing clinicians as being the only form of survey distribution with only one overlap between the counties with clinician home visitations and counties with clinicians as the sole survey administrator.

Methods for Returning the MHSIP Consumer Survey

Predominantly, county mental health departments had clients return completed MHSIP Consumer Surveys directly to administrative staff (72%), followed in order by mailing the completed instruments (43%), and then by dropping off the surveys into a box at the agency lobby (38%). Some counties (17%) reported that their clients returned their surveys directly to their clinician. However, these counties are not the same ones that had clinicians as the only method of distribution. Although it may be possible to assume that clients returned their completed survey to clinicians in sealed envelopes, only two out of the eight counties that reported that clients handed their surveys directly to clinicians actually specified that their clients did so in sealed envelopes.

Providing Assistance to Consumers Completing the MHSIP Consumer Survey

Although the MHSIP Consumer Survey is designed to be a self-report instrument that the client can complete without any assistance, some clients do require help. A significant percentage of counties (70%) reports that their administrative staff was pivotal in assisting clients to complete the MHSIP Consumer Survey when they needed help. Another notable group assisting clients was consumer/peer assistants, who were involved in 49 percent of the counties studied. Nineteen percent of counties' clinicians or case managers also provided help to clients when they needed assistance. Translators and paraprofessionals were called upon to provide help in 11 percent and 9 percent of the responding counties, respectively. In addition, three counties reported that clients sought out help from family or friends.

Riverside County offered an innovative idea for providing assistance to consumers needing help with the MHSIP Consumer Survey, suggesting the use of student volunteers from college or graduate school programs in social work or nursing who need to gain volunteer hours as part of their course requirements. These student volunteers would provide much needed assistance and at the same time relieve some of the clinic's administrative staff from answering basic questions associated with the MHSIP Consumer Survey.

Another comment that caught the Planning Council's attention was the fact that at least one county knew of a board and care facility operator who had helped clients in completing the survey. Because board and care facilities could be considered a part of the mental health system that is being evaluated by the client in the MHSIP Consumer Survey, the board and care operator should not be involved in assisting the client. At least three other counties stated that clinicians and mental health workers not assigned to the specific client needing help provided assistance in filling out the MHSIP Consumer Survey. Such intimate involvement by participants in the mental health system being reviewed is not an optimal way to obtain truly impartial empirical data. For this reason, the Planning Council recommends that board and care operators along with any clinician or mental health worker, no matter their relationship to a particular client, refrain from any involvement with the MHSIP Consumer Survey.

Administration Methods Vary within Some Counties

Three counties responding to the survey reported multiple methods for administering the survey and for providing assistance for clients needing help. One county returned ten survey forms from different community-based agencies in its county. For four of those agencies, clinicians assisted clients when they needed help with the MHSIP Consumer Survey, and for the other six agencies, consumers/peer assistants or administrative staff provided the assistance. Another county provided two different forms from county-operated clinics with slightly different procedures. The main difference in this county was whether administrative staff also had a role in addition to clinicians in distributing the MHSIP Consumer Survey. The main point, though, is that, in addition to some county mental health departments' not following the guidelines in the *Adult Performance Outcome System Clinical Training Manual*,

some mental health departments even lack consistent procedures within their own county for how they handle the MHSIP Consumer Survey.

Consumer Concerns about the MHSIP Consumer Survey

With changes being made to the adult performance outcome system, the MHSIP Consumer Survey will be one of only two instruments used to collect performance outcome data. Consequently, the Department of Mental Health and its stakeholders should be cognizant of consumer perceptions of the MHSIP Consumer Survey that may influence consumer evaluation of the system as a whole. In fact, as Riverside County is quick to point out, "Survey validity and reliability are impacted by issues that extend beyond whether or not the clinician is involved. Response bias can go in either direction."

The comments also suggest that clients may have fears that service will change or discontinue based on their answers of improvement, anxiety that without positive feedback their clinicians will not be perceived as being competent, and fears that family members and friends of consumers will be told of their progress and thus pass judgment. Being aware of these attendant fears that clients may hold will help mental health service providers' approach to educating clients about the MHSIP Consumer Survey and thereby eradicate some misplaced fears as well as help design future surveys that will be unambiguous in purpose and question framework.

Implications for the New Methodology for Collecting Performance Outcome Data

The new methodology about to be implemented will require that county mental health departments collect MHSIP Consumer Surveys twice a year with each data collection period six months apart. During each data collection period, all clients receiving treatment and services will be given the MHSIP Consumer Survey to complete. This new methodology will be implemented in May 2003. Because there is some time before this new methodology is put in place, now is an opportune time to design a system that will take into consideration most clients' concerns and eliminate as much clinician involvement as possible.

Recommendations

Recommendation 1: *The DMH should specifically instruct county mental health departments to design the new performance outcome data collection system for administering the MHSIP Consumer Survey so that clinicians do not have any contact with clients in distributing, filling out, or returning the instrument.*

Having clinician involvement in the administration of the survey casts doubt on the impartiality of the survey answers by consumers. When surveys are returned to clinicians, some consumers may assume that clinicians read the results. Moreover, when clinicians actually assist consumers in completing the MHSIP Consumer Survey, consumers who might otherwise have expressed critical opinions about that clinician would likely be reluctant to do so in such a situation. Greater emphasis must be placed on assuring consumers' confidentiality in order to elicit their honest opinions about their access to service and the quality of their care. These answers are required to improve existing services and bring about needed change.

Recommendation 2: *County mental health departments should maximize the use of consumer/peer assistants to distribute the MHSIP Consumer Surveys and to assist consumers who cannot complete the instrument by themselves.*

Replacing clinicians with more neutral assistants, such as consumers/peers, who can help clients fill out the survey when they need help will lend survey results more validity as this group would not inhibit clients' truthful responses to the instrument.

Recommendation 3: *County mental health departments should establish collaborative agreements with post-secondary institutions in their areas to recruit student volunteers to assist in the*

MHSIP Consumer Survey data collection process.

Students, both undergraduates and graduates, could supplement consumer/peer assistants in administering the MHSIP Consumer Survey. Because these students could earn college credit for such a project, this approach could be done as a volunteer program and would not generate any direct cost to the county.

Recommendation 4: *For those counties that indicated they relied on home visits to clients, the method for distributing the MHSIP Consumer Survey should be the prerogative of the consumer.*

As indicated in the report, some consumers receive their MHSIP Consumer Survey from their clinicians during home visits. However, other alternatives are available. Administrative staff, consumer/peer assistants, or student volunteers could call these clients to administer the instrument over the telephone, or the instrument could be mailed to the client, thereby eliminating contact with the clinician during the MHSIP Consumer Survey distribution. Consumers should be able to choose whether they are most comfortable with having the MHSIP Consumer Survey relayed to them over the phone or if they prefer receiving the survey by mail.

Recommendation 5: *The DMH should ensure that county mental health departments are consistently administering the MHSIP Consumer Survey among all its county-operated programs and community-based agencies.*

Because the new methodology requires that performance outcome data be collected only twice a year, county mental health departments can focus additional attention on developing uniform procedures for all facilities and agencies. Because the MHSIP Consumer Survey is the only source of input that most clients will have concerning their mental health services, the DMH should monitor the implementation of these procedures. It could incorporate monitoring efforts into the Medi-Cal onsite reviews.

Recommendation 6: *The DMH should request that counties conduct focus groups with consumers to develop an understanding of the range of issues they have with the MHSIP Consumer Survey, including misunderstandings about the items, the measurement scale, the purpose and use of the instrument, and any other concerns consumers might have with the instrument. Recommendations should also be solicited for other effective ways of obtaining feedback on client satisfaction. Based on these focus group discussions, counties will then submit summary reports to the DMH so that it can develop a state-wide report to share with key stakeholders for improving client satisfaction measurements.*

Having a focus group with consumers would free many of them to speak their mind within the safe environs of an empathetic group.

Recommendation 7: *Based on the results of the focus groups, the DMH should develop and disseminate training and technical assistance materials to county mental health departments that they can use to improve consumer understanding of and confidence in filling out the MHSIP Consumer Survey.*

Serious contemplation ought to be given to replicating a MHSIP Day similar to the one Tuolumne County had. During this MHSIP Day set aside for consumers, they learned about the survey process, how to fill out the survey, and how the survey responses will help tailor services in the future. One MHB/C consumer member of Riverside County expressed the value such an event would have: "I would like someone to walk me through. I wouldn't mind a clerical person, but maybe someone else would be good. My main concern is to understand why…it would put me at ease. But I wouldn't want help if I didn't need it, just the option." This MHSIP Day would be an ideal time to address not only the practical questions of what the survey questions really mean, but it could also be used to reduce some of the fears consumers may have regarding the "perceived outcome" scale.

In fact, more effort needs to be made on educating consumers as to why the survey needs to be completed and how their cooperation can benefit them and their peers in the future. As an MHB/C consumer member of Riverside County has shared, "I tell [consumers] we need to fill these out in order to work toward getting better services…this information is needed to improve the quality of your life. If [mental health providers] don't know, they can't help… it's like a report card they're getting." An educational campaign that addresses the need for information about the instrument and the concerns and fears that consumers have would increase the effectiveness of the MHSIP Consumer Survey as a client satisfaction tool.

In conclusion, the clinician needs to be removed from the survey process altogether at the same time that the consumers receive more education on the benefits that the completion of the MHSIP Consumer Survey can have in their lives. Consumer cooperation and active engagement throughout the survey process is needed to assure that client satisfaction data are a meaningful part of the State's quality improvement process. Positive feedback is also required to ensure that programs that are working can be recognized and replicated across the various counties.

Appendix 1

Appendix 2

July 16, 2002

To: Local Mental Health Director
Mental Health Board/Commission Chairperson

From: Daphne Shaw, Chairperson
Quality Improvement Committee

Subject: Administration Method for MHSIP Consumer Survey

The California Mental Health Planning Council is mandated by Section 5772(c) of the Welfare and Institutions Code to review the performance of mental health programs annually based on performance outcome data. The Planning Council has assigned this responsibility to its Quality Improvement Committee.

The Quality Improvement Committee has established a goal to review the performance of local mental health programs in late 2002 or early 2003 by using data reported by clients on the MHSIP Consumer Survey. Our plans include developing a guide for mental health boards and commissions (MHB/Cs) to aid them in interpreting the data and providing a format for reporting the results of their analysis to the Planning Council.

Before working on the guide for analyzing the MHSIP Consumer Survey data, the Planning Council wants to study how counties are administering the instrument to clients. We are hearing concerns from clients that their clinicians are involved in the administration process, which clients find intimidating. Involvement of clinicians inhibits candid expression of client satisfaction, which is the intention of administering the instrument. The enclosed excerpt from the Adult Performance Outcome System Clinical Training Manual describes the confidentiality concerns about administering the MHSIP Consumer Survey and provides instructions about how the instrument is supposed to be administered.

We would like the MHB/C in collaboration with the mental health department to conduct an inquiry into the method of administration used in your county to administer the MHSIP Consumer Survey. We have enclosed a survey questionnaire for you to fax to our office upon completion of your inquiry. Our fax number is (916) 654-2739. **We need to receive this survey no later than September 1, 2002.**

If you have any questions, please contact Ann Arneill-Py, the Planning Council's Executive Officer, at (916) 654-3585. She can also be reached by email at aarneill@dmhhq.state.ca.us. Your assistance will be greatly appreciated and will further the State's understanding of the validity of these data.

Attachments

Please answer the following questions concerning how your county administers the MHSIP Consumer Survey:

1. Do clinicians have any contact with clients during the administration of the MHSIP Consumer Survey?

   ____ No ____ Yes (if yes, please check all that apply below:)

   ____ Clinicians hand the client the MHSIP Consumer Survey to fill out.

   ____ The client completes the MHSIP Consumer Survey and then returns it to the clinicians.

   ____ Clinicians assist the client in completing the MHSIP Consumer Survey if the client needs help.

   ____ Clinicians are involved in administering the MHSIP Consumer Survey to the clients because client contact is done through home visits.

2. Please indicate the methods of administration for the MHSIP Consumer Survey used in your county. This question assumes that the instrument is completed by the client without assistance. *Please check all responses that apply.*

   ____ Administrative staff provide the instrument to the client

   ____ The instrument is mailed to the client

   ____ A consumer or peer assistant provides the instrument to the client

   ____ The client returns the instrument by mail

   ____ The client drops off instrument in a box in the lobby

   ____ The client returns the instrument to administrative staff

   ____ An interactive telephone voice recognition system is used

   ____ The instrument is read to the client over the telephone by staff

   ____ A computer-administered system is used by the client

   ____ Group administration used

   ____ Other (please specify) _____

   _____

3. If the consumer needs assistance completing the MHSIP Consumer Survey, who provides the assistance? *Please check all responses that apply.*

   ____ The client's clinician or therapist

   ____ The client's case manager

   ____ A consumer or peer assistant

   ____ A translator

   ____ A paraprofessional

   ____ Administrative support staff

   ____ Other (please specify)

   _____

4. Are there any comments you would like to make regarding the MHSIP Consumer Survey and its use in your county or anything the Planning Council should consider in working with the MHSIP Consumer Survey data? Please attach an additional page with your comments.

Thank you for your assistance.